Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ASSOCIATION OF UNIVERSITY RADIOLOGIST
5401 KINGSTON PIKE STE 540
KNOXVILLE TX 37919

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN & FOREIGN INSURANCE CO

Carrier's Austin Representative Box
Box Number 11

MFDR Tracking Number
M4-11-1640-01

MFDR Date Received
JANUARY 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim and 3-31-10 no auth. Pt was admitted via ER claims have been resubmitted for claims for reconsideration. Pt told he would call WC on 5-3-10 – 7-6-10 pt calls sent WC all information denied timely- This claim is not timely – filed on 2-9-10 originally and 4 other times. Hospital was paid."

Amount in Dispute: $5,258.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A position summary was not submitted by the respondent or it's agent.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2010 through February 1, 2010	Radiological Services	$5,258.44	$1,740.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code $408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §133.2 defines emergency.
4. 28 Texas Administrative Code §134.600, effective May 2, 2006, sets out the procedures for preauthorization, concurrent review or voluntary certification of healthcare.
5. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of workers' compensation professional services provided on or after March 1, 2008.
6. Texas Labor Code §134.1, effective March 1, 2008, 330 TexReg 626, provides for fair and reasonable

reimbursement of health care in the absence of an applicable fee guideline.

7. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Services not provided or authorized by designated (network/primary care) providers.
   - The time limit for filing has expired.
   - The time limit for filing has expired. Services denied at time of preauthorization. No Emergency/Urgent care.

Issues

1. Is the out of state provider/services eligible for Medical Fee Dispute Resolution?
2. Were the services billed to the carrier timely?
3. Did the services require preauthorization as non-emergency healthcare?
4. Is the requestor due reimbursement?

Findings

1. The requestor provided services in the state of Tennessee to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Review of the submitted documentation by the requestor finds an explanation of benefits dated March 18, 2010. The Division finds that the documentation submitted by the requestor supports that a medical bill was submitted for payment to the insurance carrier with 95 days after the date on which the health care services were provided to the injured employee; therefore, the insurance carrier's denial is not supported.
3. Per 28 Texas Administrative Code §134.600(c) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (A) An emergency, as defined by Chapter 133 of this title (relating to General Medical Provisions);

   (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor states that "Pt was admitted via ER."

   28 Texas Administrative Cod §133.2(a)(4) defines "Emergency—either a medical or mental health emergency as follows:

   (A) A medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

   (i) placing the patient's health or bodily functions in serious jeopardy, or

   (ii) Serious dysfunction of any body organ or part."

   Review of the submitted medical records indicates that the claimant was admitted to the hospital because he suffered a seizure. This condition meets the definition per 28 Texas Administrative Code §133.2(a)(4)(A)(i). Therefore, the respondent's denial based upon no preauthorization and not emergency/urgent care is not supported. Therefore, the disputed services will be reviewed in accordance with Division rules and statutes.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this

annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = Maximum Allowable Reimbursement (MAR). The 2010 DWC conversion factor for this service is 54.32; the Medicare conversion factor is 36.0791.

CPT Code 70450-26 – (54.32÷36.0791) x $42.33 = $63.73 x 2 Units = $127.46

CPT Code 73030-26 – (54.32÷36.0791) x $9.64 = $14.51

CPT Code 70553-26 – (54.32÷36.0791) x $117.48 = $176.88

CPT Code 75662-26 – (54.32÷36.0791) x $84.20 = $126.77

CPT Code 75685-26 – (54.32÷36.0791) x $238.52 = $359.11

CPT Code 75671-26 – (54.32÷36.0791) x $83.95 = $126.39

CPT Code 75774-26 – (54.32÷36.0791) x $18.17 = $27.36 x 2 Units = $54.72

CPT Code 36217 – (54.32÷36.0791) x $339.32 = $510.87

CPT Code 36218 – (54.32÷36.0791) x $53.94 = $81.21 x 3 Units = $243.63

The requestor appended modifier -59 to CPT Code 75685-26. According to CCI data, there are no CCI conflicts for this code. The requestor has attached an incorrect modifier. As a result, the amount ordered is $0.00.

The requestor appended modifier -59 to CPT Code 36216, 2 Units. According to CCI Edits CPT Code 36217 (Column 1) has a CCI conflict with Code 36216 (Column 2). A modifier is allowed to override this relationship.

CPT Code 36217 is defined as: Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family.

CPT Code 36216 is defined as: Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family.

Modifier -59 is defined as: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, **different site or organ system**, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Review of the code definitions finds that both codes are within the thoracic or brachiocephalic branch, within a vascular family. As a result, the amount ordered for CPT Code 36216-59 is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,740.34.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,740.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.